The pain, however, may be reasonably expected to be occasionally present, in acute and painful diseases of this organ, in one or the other shoulder.

As the "head" of the pancreas is the part most commonly diseased, either the right or left vagus may be affected, according to the lobe attacked; or both nerves, if both lobes suffer.

There is confessedly no group of symptoms that can be relied upon as pathognomonic of pancreatic disease pure and simple. I have consulted all the authors within my reach to see if any had noticed the shoulder pain as one feature of the group. The usual account goes to show that the pain is seated in the gland itself, and radiates or extends to the spine, the wall of the chest—often on the right side, and running up as far as the lower part of the shoulder—radiations doubtless along the course of the nerves of the organ back to the solar plexus, and thence to the splanchnic and intercostal nerves, and to the spine.

The only authors who, to my knowledge, distinctly mention the shoulder pain in these diseases, are Dr. J. R. Wardell and Dr. G. Andral. The former, in the third volume of Reynolds's *System of Medicine*, states that, of inflammation of the pancreas, "the cardinal symptoms are a dull, heavy, aching pain, deep down below the centre of the epigastric region, which radiates through to the back, left shoulder, and left lumbar space, simulating the pain experienced in renal calculus." But this pain of the shoulder is not said to be in the top of the shoulder.

The pain in pancreatic, as in liver diseases, may perhaps be more frequently discovered on a more attentive and minute examination of the cases as they occur. I cannot say that I have myself had occasion to notice its presence. In splenic diseases, however, the pain is often present.

The latter physician, in his *Cours de Pathologie Interne* (tom. i, p. 167), gives the following case, taken from *Hufeland's Journal*, April, 1822. "Une villageoise, en 1820, mit au monde un sixième enfant. Immédiatement après la délivrance elle fut saisie d'une fièvre grave. La malade était pâle, émaciée, extenuée par des sueurs abondantes et une continuelle salivation, avec éructation d'une liqueur filante, jaunâtre, sans odeur ni saveur. La quantité de ce liquide sécrété dans vingt-quatre heures dépassait deux livres; la bouche et le gosier présentaient un aspect naturel; tantôt il y avait constipation, tantôt diarrhée, et les selles alors étaient semblables aux mucosités rendu par la bouche. Anorexie, grande soif qu'on ne parvenait à calmer qu'en humectant souvent la bouche, car la plus petite quantité de boisson occasionait des spasmes de l'estomac. Le soir, exacerbation de la fièvre. En outre, douleurs pongitives et transitoires dans la côté gauche de la poitrine, toux sèche, fréquentes palpitations, syncopes au moindre mouvement. La malade éprouvait *dans le dos des douleurs qui se propageaient jusque dan l'épaule et le bras droits;* sentiment de pression à la region précordiale," etc.

The patient fully recovered in three months, and bore another child.

These citations are not, it must be confessed, very satisfactory. Further and more minute observation may give us sufficient pathological proof that the pancreas really belongs to the pneumogastric series of organs, and that its morbid influence may be extended to one or other shoulder-tip.

THE ANTICIPATION OF POST PARTUM HÆMORRHAGE.*

By EWING WHITTLE, M.D.,
Lecturer on Medical Jurisprudence in the Royal Infirmary School of Medicine, Liverpool.

IT is now more than twenty years since I read a paper before the Medical Society of Liverpool, in which, as I believed, I demonstrated to that Society the fact, that the probable occurrence of *post partum* hæmorrhage in any case of parturition could be diagnosed beforehand, and, being diagnosed, could be prevented. If this assumption be sound, you will readily admit that this cannot be too widely known, and that it is a reproach to the profession that we still occasionally hear of cases of death from *post partum* hæmorrhage. Very early in my career in the practice of obstetric medicine, I observed that cases of parturition in which *post partum* hæmorrhage occurred, were always marked by the pains during labour being of a peculiar character. Having my attention directed to this point, I further observed that *post partum* hæmorrhage *never* occurred in any case of labour in which this peculiar character of the pains was absent. The pains are of this kind: they are strong and quick; they do not gradually culminate into a strong pain and subside again, but they are sharp, quick, and cease almost suddenly; and the intervals between the pains are long in proportion to the length of the pains. In an ordinary case, for one or two hours before the completion of labour, the intervals will average about three times the length of the pains; *i.e.*, if the pains last each from fifty to sixty seconds, the intervals will average a little less than three minutes. Now, if the pains last each only from forty to fifty seconds, and are of the sharp character I have described, with intervals lasting five or six minutes, though the labour may proceed steadily and the head advance a little with every pain, you will be sure to have hæmorrhage after delivery is completed, unless you anticipate it by altering the character of the pains, in making the pains longer and the intervals shorter. It is very easy to understand how this comes to be the case: the uterus is contracting sharply, and then becoming fully relaxed; after the child is born, a relaxation follows; one or two sharp pains expel the placenta with a gush of blood, and the uterus again relaxes, continuing the same tendency which existed before the delivery of the child.

Some of my friends will say that this may be very well, but that all this may be prevented by carefully attending to the maintenance of a steady contraction of the uterus by following down the expulsion of the child and placenta, and keeping the uterus firmly grasped until all danger of relaxation has passed away; that, by attending to this point carefully, during an experience of many years, they have never had a serious case of hæmorrhage. But I would warn them that, no matter how long, through good fortune or good care, they may have escaped this painful trial, they never know when they may happen to fall in with a patient of weak, flabby fibre, and low nervous power, in whom they may find it impossible almost to induce active uterine contraction in time to save her from the effects of the hæmorrhage.

Having recognised the necessity for interference in any case as soon as the os is fully dilated, I give a full dose of ergot. If this do not improve the character of the pains at the end of an hour, or thereabouts, I repeat it; I scarcely ever find a second dose necessary. In dealing with primiparæ, caution is required, first, not to administer ergot until the soft parts are pretty well dilated as well as the os uteri; and the drug should be administered in much smaller doses, as it sometimes acts with unusual energy in primiparæ. Generally, in about twenty minutes or half an hour after the ergot has been administered, the pains increase in length and frequency, and when the labour is over, the uterus maintains a good contraction. The ergot which I use is a liquid extract twice the strength of that of the *Pharmacopœia*, of which I give a teaspoonful when I think a full dose is indicated.

I have pursued this practice now for more than twenty years. During this time I have attended 3,750 labours, and among them I have had one case of *post partum* hæmorrhage; that case occurred about three o'clock one winter's morning, when I happened to have no ergot with me. I foresaw that it would happen, and was able to prevent its being very serious by adopting the ordinary means.

If the gentlemen around me will look out for these cases in their own practice, I am sure they will occasionally recognise them, and by adopting the means that I suggest, they will secure the safety of their patients, and at the same time relieve themselves from a constant cause of anxiety.

I feel that, by this discovery, I have eliminated from my own practice the danger of *post partum* hæmorrhage, and I earnestly urge you all to try and verify for yourselves the hint which I now offer you.

* Read before the Obstetric Medicine Section at the Annual Meeting of the British Medical Association in London, August 1873.

CLINICAL MEMORANDA.

LARVÆ IN THE EXTERNAL EAR.

AN elderly lady complained of uneasiness and irritation in her left ear, and was advised to syringe it well with warm soap and water. On doing so, a number of live maggots, about the sixth part of an inch in length, were expelled from the meatus. I brushed the interior of the canal with a mixture of sulphurous acid and glycerine, and again used the syringe, when some more maggots were washed out, dead. The irritation not ceasing yet, I repeated the application, and two days later one very large maggot crawled out. A further use of the acid and glycerine, followed by copious syringing, brought away a large quantity of minute eggs, after which all the unpleasant symptoms vanished. No ulceration was to be obseved in or about the tympanum, nor any apparent inducement for the presence of the maggots. Some insect—probably a fly or "blue-bottle", must have found its way into the meatus during sleep, and there deposited the eggs.

LOUIS LEWIS, M.R.C.S.